**Texas Department of Insurance, Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

Requestor's Name and Address:

The Clinic for Special Surgery
900 12th Avenue
Fort Worth TX 76104

MFDR Tracking #: M4-05-A969-01

DWC

Injured

Date

Respondent Name and Box #:

LIBERTY MUTUAL INSURANCE CO
Rep Box # 28

Employ

Insurance

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUME

Requestor's Position Summary: "...the carrier did not consider CPT code 23101 as primary...the other two billed procedures have already been discounted on the HCFA form by 50%..."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $1543.46
3. CMS 1500s
4. Operative report

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "...the medical dispute has been re-reviewed and our position remains the same..."

Principal Documentation:

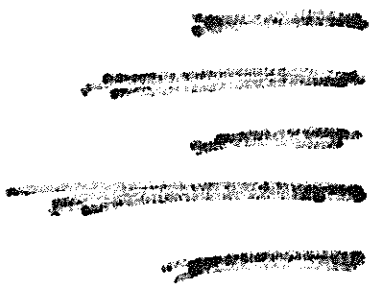
1. DWC-60 package

## PART IV: SUMMARY OF FINDINGS

| Eligible Dates of Service (DOS) | CPT Codes and Calculations | Denial Codes | Part V Reference | Amount Ordered |
|---|---|---|---|---|
| 4/19/05 | 23101-SG (See Calculations Below) | U849, Z560, X133 | 1, 2 | $1543.46 |
| **Total /Due:** | | | | $1543.46 |

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective March 10, 2005, set out the reimbursement guidelines



1. Per review of Box 32 on CMS-1500, zip code 76104 is located in Tarrant County (Reasonable Charge Locality 28). The maximum reimbursement amount, under Rule §134.402, is determined by locality.
2. Code 23101for date of service 4/19/05, was reduced with code "U849 – This multiple procedure was reduced 50% according to Fee Schedule or usual and customary guidelines," "Z560 – The charge for this procedure exceeds the Fee Schedule or usual and customary allowance" and "X133 – This charge was not reflected in the report as one of the procedures or services performed." Review of the operative report supports the rendering of procedure 23101.Code 23101 is the primary procedure on this date of service with a Payment Grouping of "7", and not subject to the Multiple Procedure Rule. The Respondent initially made payment in the amount of $279.91, but upon request for reconsideration, the Respondent recouped this amount in the subsequent payment of another code. Per the DWC-60 Table of Disputed Services, Requestor is seeking reimbursement in the amount of $1543.56. Per 28 Texas Administrative Code §134.402 (d)(1), the MAR for code 23101 exceeds the amount of reimbursement being requested. Therefore, reimbursement in the amount of $1543.56 is recommended.

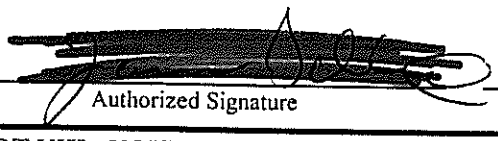
## PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. §413.011(a-d), Section. §413.031 and Section. §413.0311
28 Texas Administrative Code Section. §134.1,
28 Texas Administrative Code Section. §134.402
Texas Government Code, Chapter 2001, Subchapter G

## PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to **additional** reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$1543.36** plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

**ORDER:**



Authorized Signature | Medical Fee Dispute Resolution Officer | 12/21/07 Date

## PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**